2005 DRAFTING REQUEST

Bill

Received: **10/21/2004**

Received By: **chanaman**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget**

By/Representing: **Jablonsky**

This file may be shown to any legislator: **NO**

Drafter: **chanaman**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies: **PJK**

Submit via email: **NO**

Pre Topic:

DOA:.....Jablonsky, BB0041 -

Topic:

HIRSP pharmacy reform

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/P1	chanaman 01/03/2005	jdyer 01/04/2005	rschluet 01/04/2005	_____ _____	lemery 01/04/2005		State
/P2	chanaman 01/18/2005	jdyer 01/18/2005	rschluet 01/18/2005	_____ _____	sbasford 01/18/2005		State
/P3	chanaman 01/24/2005	jdyer 01/24/2005	rschluet 01/24/2005	_____ _____	lnorthro 01/24/2005		State
/P4	chanaman 01/24/2005	jdyer 01/24/2005	rschluet 01/24/2005	_____ _____	sbasford 01/25/2005		State
/P5	chanaman 01/26/2005	jdyer 01/26/2005	rschluet 01/26/2005	_____ _____	lnorthro 01/26/2005		State

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	chanaman 02/01/2005	jdyer 02/01/2005		_____ _____			
/P6			rschluet 02/01/2005	_____ _____	lnorthro 02/01/2005		State

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pc 2/1 jld

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/P4	chanaman 01/24/2005	jdyer 01/24/2005	rschluet 01/24/2005	_____ _____	sbasford 01/25/2005		State

FE Sent For:

/P5 1/26 jld

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Instructions:

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/P3	chanaman 01/24/2005	jdyer 01/24/2005	rschluet 01/24/2005	_____ _____	lnorthro 01/24/2005		State

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FE Sent For:

/P3 1/24 jld

<END>

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FE Sent For:

P2 1/18 jld

<END>

2005 DRAFTING REQUEST

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This file may be shown to any legislator: **NO**

Drafter: **chanaman**

May Contact:

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Subject: **Insurance - health**

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HIRSP pharmacy reform

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Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/P1	chanaman	P1 1/3 jld					State

FE Sent For:

<END>

BB0041

2003-05 Budget Bill Statutory Language Drafting Request

- Topic: HIRSP Pharmacy
- Tracking Code: (Assigned by Government Operations Team)
- SBO team: HRT
- SBO analyst: Susan Jablonsky
  - Phone: 7-9546
  - Email: sue.jablonsky@doa.state.wi.us
- Agency acronym: DHFS
- Agency number: 435

DHFS

Department of Health and Family Services
2005-2007 Biennial Budget Statutory Language Request
September 21, 2004

HIRSP Pharmacy Reform

Current Language

Under s.149.14(5)(e) the Department is allowed by rule to establish prescription drug coverage copayment amounts, coinsurance rates, and co-payment and coinsurance out-of-pocket limits over which the plan will pay 100% of the covered costs.

Under 149.142(1)(b), it is required that the HIRSP payment rates for prescription drugs be the allowable charge paid by the Medicaid program.

Proposed Change

Restructure HIRSP pharmacy drug coverage for recipients by establishing in statute the following: (a) set the out-of-pocket maximum for drug coverage at $300 for Plan1A and Plan 2, and $400 for Plan 1B; (b) require that HIRSP have a three-level copayment structure for pharmacy benefits, with HIRSP policyholders paying $5, $15, and $35 for most generic and brand name drugs; (c) specify that the out-of-pocket maximums would only apply to drugs at the $5 and $15 copayment levels; and (d) provide that the copayments and out-of-pocket maximums may be changed by administrative rule.

In addition, remove the statutory provision requiring HIRSP to have the same payment rates as Medicaid. Allow the Department, with the approval of the Board, to set the drug reimbursement rates for HIRSP.

Effect of the Change

Under current statute all three plans require policyholders to pay a coinsurance of 20% of the allowed costs up to $25 per prescription. However, the coinsurance is subject to out-of-pocket maximums of $750 per year for Plan 1A, $1,000 per year for Plan 1B, and $125 per year for Plan 2.

This proposal would restructure HIRSP's pharmacy drug coverage to require that the out-of-pocket maximum for drug coverage be $300 for Plan1A and Plan 2, and $400 for Plan 1B. Also, it would require that all three HIRSP plans will have a three-level copayment structure for pharmacy benefits, with HIRSP policyholders paying $5, $15, and $35 for most generic

and brand name drugs. The out-of-pocket maximums would only apply to drugs at the $5 and $15 copayment levels. These amounts and limits could be changed by administrative rule.

In addition, remove the requirement that the HIRSP reimbursement rate for drugs be the Medicaid rate.

Rationale for the Change

Revising the HIRSP drug coverage benefit will make the program cost effective and more consistent with private market plans.

An actuarial analysis estimated that if HIRSP went to a multi-tiered drug benefit with a $300 out-of-pocket maximum for Level 1 and Level 2 drugs, HIRSP prescription drug costs would decrease by $1.3 million, or 3.7%. Policyholder costs would increase on average by $46 per year for Plan 1A, $26 per year for Plan 1B, and $446 per year for Plan 2.

Removing the requirement that the HIRSP payment rates for prescription drugs be the allowable charge paid by the Medicaid program would allow the Department to negotiate lower reimbursement rates. The Medicaid rate in FY05 is the average wholesale price (AWP) minus 13% for brand-name drugs or a Maximum Allowed Cost (MAC) for generics. In addition to the cost of the drug, there is a dispensing fee of $4.38 per prescription.

It is estimated that if HIRSP negotiated drug prices similar to private rates the program could implement reimbursements of AWP-15% and a dispensing fee of $2.55. Based on CY03 drug expenditures, removing the requirement that the HIRSP payment rate equal the rate in the Medicaid program for prescription drugs would result in estimated annual savings of $3,031,300 SEG over the 05-07 biennium.

Desired Effective Date:	Upon Passage of the Budget Bill
Agency:	DHFS
Agency Contact:	Curtis Cunningham
Phone:	266-5362

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–0578/P1
CMH:...:...

DOA:.....Jablonsky, BB0041 – HIRSP pharmacy reform

FOR 2005–07 BUDGET –– NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The Health Insurance Risk–Sharing Plan (HIRSP) under current law provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition (eligible persons). Also eligible for coverage are persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past (eligible individuals). DHFS and a board of governors (board) administer HIRSP.

Under current law, the HIRSP payment rates for prescription drugs are the same as the payment rates for the Medicaid program. This bill allows DHFS, with the approval of the board, to set the prescription drug payment rates.

Under current law, DHFS is allowed by rule to establish for prescription drug coverage copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which HIRSP will pay 100 percent of the covered costs incurred by the covered person during the remainder of the calendar year. This bill establishes the out–of–pocket limit for prescription drug coverage at $300 for eligible persons and establishes the out–of–pocket limit for prescription drug coverage at

~~$400 for eligible individuals.~~ This bill also requires DHFS to establish a three–tiered copayment structure for prescription drug benefits, with covered persons paying $5, $15, and $35 for most generic and brand name prescription drugs. The out–of–pocket limits apply only to prescription drugs at the $5 and $15 copayment tiers; the prescription drugs at the $35 tier do not count toward the out–of–pocket limits. This bill allows DHFS to change the copayment and out–of–pocket limits by administrative rule.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 149.14 (5) (e) of the statutes is amended to read:

149.14 **(5)** (e) Subject to sub. (8) (b), ~~the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and~~ copayment and coinsurance out–of–pocket ~~limits~~ limit for prescription drug coverage under sub. (3) (d) over which the plan will pay ~~100%~~ of covered costs under sub. (3) (d) is $300. The department shall establish a 3–tiered copayment structure for prescription drugs of $5, $15, and $35. The out–of–pocket limit applies only to prescription drugs at the $5 and $15 tiers. The department may provide subsidies for prescription drug copayment amounts paid by eligible persons under s. 149.165 (2) (a) 1. to 5. Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board, and the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments and coinsurance paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

SECTION 2. 149.142 (1) (b) of the statutes is amended to read:

149.142 **(1)** (b) The payment rate for a prescription drug ~~shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug~~ may be set by the department, subject to the approval of the board. Notwithstanding s. 149.17 (4), ~~the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and~~ the rate may not be adjusted under s. 149.143 or 149.144.

#5.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16; 2003 a. 33.

SECTION 3. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. Subject to s. 149.14 (8) (b), the ~~department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and~~ copayment and coinsurance out–of–pocket ~~limits~~ limit for prescription drug coverage under this section over which the plan will pay ~~100%~~ 100 percent of covered costs for prescription drugs under this section is $400. The department shall establish a 3–tiered copayment structure for prescription drugs of $5, $15, and $35. The out–of–pocket limit applies only to prescription drugs at the $5 and $15 tier. Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board, and the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments and coinsurance paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

SECTION 9321. Initial applicability; health and family services.

(1) HEALTH INSURANCE RISK–SHARING PLAN PRESCRIPTION DRUG COPAYS AND OUT–OF–POCKET LIMITS. The treatment of sections 149.14 (5) (e), 149.142 (1) (b), and

#6.

149.146 (2) (am) 5. of the statutes first applies to policies under the Health Insurance Risk–Sharing Plan that are issued or renewed on the effective date of this subsection.

(END)

Memo

Please return this memo/draft to me — for my records & for training. Thanks, Cath

To: Cathlene

From: Pam

Subject: LRB–0578

1. Organization–wise, I think you should start with the part about DHFS establishing the 3–tiered copayment structure, and then come in with the out–of–pocket limit (in both the statutory text and the analysis text), because conceptually the copayments must be paid first before you could ever reach the out–of–pocket maximum.

2. You don't need to keep the "Subject to sub. (8) (b)" at the beginning because DHFS has no discretion about the copayment amounts.

3. So, after you've set out the copayment amounts and the out–of–pocket limit, next would be a good place to mention that only the $5 and $15 apply to the limit. Instead of saying that the out–of–pocket limit applies only to those copayments, I'd say that only those copayment amounts count toward the out–of–pocket limit.

4. The copayments, etc., under par. (e) should not be made subject to approval by the board because they are specified in the statute, not established by rule. You need to give DHFS the authority to change the statutory amounts by rule, which you've done, but DHFS may not necessarily want to require the approval of the board for those rules.

→ Here "subject to sub. (8)(b)" would be appropriate

5. I think the payment rate for drugs *should be* adjustable under s. 149.143 or 149.144. It wasn't adjustable before because it *had* to be the allowable charge under MA. (note s. 149.142(2))

6. Even though HIRSP does have individual policies, I think the initial applicability should be, "first applies to prescription drug coverage in the first plan year beginning after the effective date of this subsection." I would do this because: I'm not sure if the plan year begins on July 1 or January 1; I'm not sure if the policies mention specific drug copays and out–of–pocket limits; and I'm not sure if DHFS has the ability, under the language of the policies, to change things during a plan year. If they want something different, they can let you know.

Let me know if you want to discuss or have any questions about my comments — after you've had a chance to digest them.

(I've tried to note on the draft the comment number that is applicable.)

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–0578/P1
CMH&PJK:...:...

DOA:.....Jablonsky, BB0041 – HIRSP pharmacy reform

FOR 2005–07 BUDGET –– NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

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OTHER HEALTH AND HUMAN SERVICES

The Health Insurance Risk–Sharing Plan (HIRSP) under current law provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. DHFS and a board of governors (board) administer HIRSP.

Under current law, HIRSP payment rates for prescription drugs are the same as payment rates under the Medical Assistance (MA) program. This bill allows DHFS, with the approval of the board, to set HIRSP prescription drug payment rates.

Under current law, DHFS is allowed by rule to establish for prescription drug coverage copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which HIRSP will pay 100 percent of the covered costs incurred by the covered person during the remainder of the calendar year. This bill requires DHFS to establish a three–tiered copayment structure for prescription drug

benefits, with covered persons paying $5, $15, and $35 for most generic and brand name prescription drugs. This bill establishes the out–of–pocket limit for prescription drug coverage at $300 or $400, depending on coverage selected. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limits; the $35 copayment amount does not count toward the out–of–pocket limits. This bill also allows DHFS to change the copayment and out–of–pocket limits by administrative rule.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 149.14 (5) (e) of the statutes is amended to read:

149.14 **(5)** (e) ~~Subject to sub. (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under sub. (3) (d) over which the plan will pay ~~100%~~ 100 percent of covered costs under sub. (3) (d) is $300. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. The department may provide subsidies for prescription drug copayment amounts paid by eligible persons under s. 149.165 (2) (a) 1. to 5. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board~~ Subject to sub. (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments and coinsurance paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

History: 1979 c. 313; 1981 c. 39 s. 22; 1981 c. 83; 1981 c. 314 ss. 117, 146; 1983 a. 27; 1985 a. 29 s. 3202 (30); 1985 a. 332 s. 253; 1987 a. 27, 239; 1989 a. 332; 1991 a. 39, 269; 1995 a. 463; 1997 a. 27 ss. 3026c, 4847 to 4859; Stats. 1997 s. 149.14; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

SECTION 2. 149.142 (1) (b) of the statutes is amended to read:

149.142 **(1)** (b) The payment rate for a prescription drug ~~shall be the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144~~ may be set by the department, subject to the approval of the board.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16; 2003 a. 33.

SECTION 3. 149.142 (2) of the statutes is amended to read:

149.142 **(2)** ~~Except as provided in sub. (1) (b), the~~ The rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

History: 1999 a. 9; 2001 a. 16.

SECTION 4. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. ~~Subject to s. 149.14 (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under this section over which the plan will pay ~~100%~~ 100 percent of covered costs for prescription drugs. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board~~ under this section is $400. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. Subject to s. 149.14 (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments and coinsurance paid by an eligible person under this subdivision

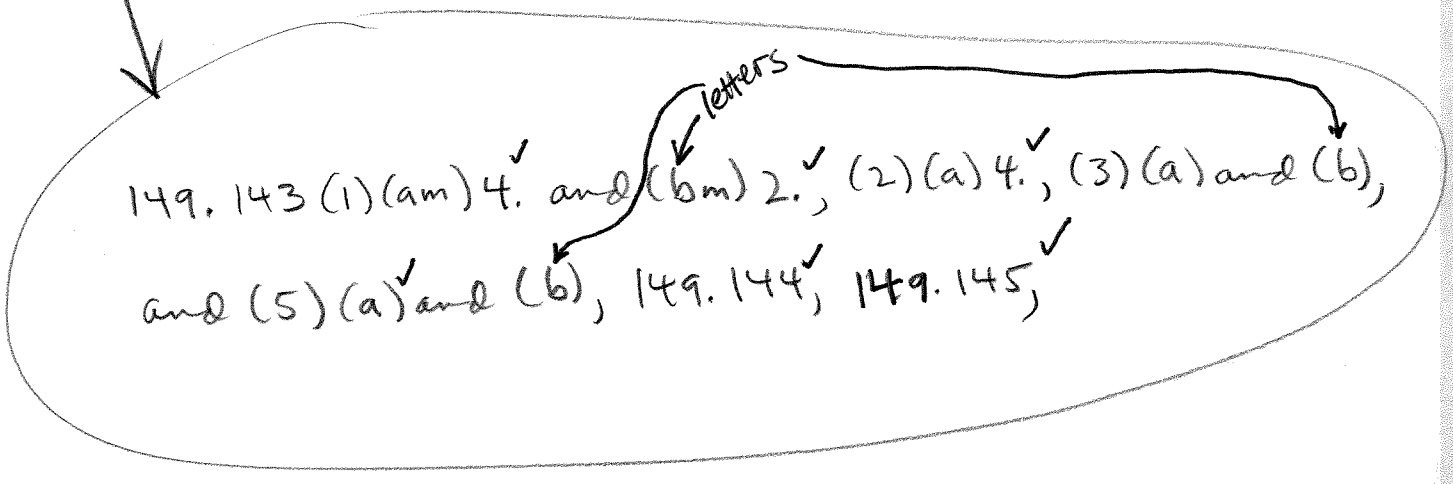
are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

History: 1997 a. 27 ss. 4860c, 4860d; Stats. 1997 s. 149.146; 1997 a. 237; 1999 a. 9, 165; 2001 a. 16; 2003 a. 33.

SECTION 9321. Initial applicability; health and family services.

(1) HEALTH INSURANCE RISK-SHARING PLAN PRESCRIPTION DRUG COPAYS AND OUT-OF-POCKET LIMITS. The treatment of sections 149.14 (5) (e), 149.142 (1) (b) and (2), and 149.146 (2) (am) 5. of the statutes first applies to prescription drug coverage in the first plan year beginning after the effective date of this subsection.

(END)



INSERT 3–9

SECTION 1. 149.143 (1) (am) 4. of the statutes is amended to read:

149.143 **(1)** (am) 4. Fourth, notwithstanding par. (bm), by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subds. 1. to 3. are insufficient to pay 60% of plan costs.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 2. 149.143 (1) (bm) 2. of the statutes is amended to read:

149.143 **(1)** (bm) 2. Fifty percent from adjustments to provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 3. 149.143 (2) (a) 4. of the statutes is amended to read:

149.143 **(2)** (a) 4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year~~, subject to s. 149.142 (1) (b),~~ by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) 2. and as provided in s. 149.145.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 4. 149.143 (3) (a) of the statutes is amended to read:

149.143 **(3)** (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2.,

Ins 3-9 contd

by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. ~~and s. 149.142 (1) (b).~~ strike plain

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 5. 149.143 (3) (b) of the statutes is amended to read:

149.143 **(3)** (b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (bm) ~~but subject to s. 149.142 (1) (b).~~

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 6. 149.143 (5) (a) of the statutes is amended to read:

149.143 **(5)** (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates~~, subject to s. 149.142 (1) (b),~~ for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 7. 149.143 (5) (b) of the statutes is amended to read:

149.143 **(5)** (b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually~~, subject to s. 149.142 (1) (b)~~. The department

Lns 3-9 cont'd

may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate~~, subject to s. 149.142 (1) (b)~~.

History: 1997 a. 27; 1999 a. 9, 165; 2001 a. 16, 109; 2003 a. 33.

SECTION 8. 149.144 of the statutes is amended to read:

149.144 Adjustments to insurer assessments and provider payment rates for premium, deductible, and prescription drug copayment reductions. The department shall, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ~~ss. 149.142 (1) (b) and~~ s. 149.143 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165, deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

History: 1997 a. 27 ss. 4840c, 4845c; 1999 a. 9; 2001 a. 16; 2003 a. 33.

SECTION 9. 149.145 of the statutes is amended to read:

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143, 149.144, and 149.146 for determining premium rates, insurer assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) ~~and subject to s. 149.142 (1) (b)~~, from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The

lns 3-9 cont'd

department may not implement a program budget established under this section unless it is approved by the board.

History: 1997 a. 27; 1999 a. 9; 2001 a. 16; 2003 a. 33.

(END OF INSERT 3–9)

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–0578/P1
CMH&PJK:jld:rs

DOA:.....Jablonsky, BB0041 – HIRSP pharmacy reform

FOR 2005–07 BUDGET –– NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The Health Insurance Risk–Sharing Plan (HIRSP) under current law provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. DHFS and a board of governors (board) administer HIRSP.

Under current law, HIRSP payment rates for prescription drugs are the same as payment rates under the Medical Assistance (MA) program. This bill allows DHFS, with the approval of the board, to set HIRSP prescription drug payment rates.

Under current law, DHFS is allowed by rule to establish for prescription drug coverage copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which HIRSP will pay 100 percent of the covered costs incurred by the covered person during the remainder of the calendar year. This bill requires DHFS to establish a three–tiered copayment structure for prescription drug

benefits, with covered persons paying $5, $15, and $35 for most generic and brand name prescription drugs. This bill establishes the out–of–pocket limit for prescription drug coverage at $300 for persons who are also covered under Medicare and at $300 or $400 for other covered persons, depending on coverage selected. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limits; the $35 copayment amount does not count toward the out–of–pocket limits. This bill also allows DHFS to change the copayment and out–of–pocket limits by administrative rule.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 149.14 (5) (e) of the statutes is amended to read:

149.14 **(5)** (e) ~~Subject to sub. (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under sub. (3) (d) over which the plan will pay ~~100%~~ 100 percent of covered costs under sub. (3) (d) is $300. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. The department may provide subsidies for prescription drug copayment amounts paid by eligible persons under s. 149.165 (2) (a) 1. to 5. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board~~ Subject to sub. (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments ~~and~~ any ~~coinsurance~~ paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

SECTION 2. 149.142 (1) (b) of the statutes is amended to read:

149.142 **(1)** (b) The payment rate for a prescription drug shall be ~~the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144~~ set by the department, subject to the approval of the board.

SECTION 3. 149.142 (2) of the statutes is amended to read:

149.142 **(2)** ~~Except as provided in sub. (1) (b), the~~ The rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

SECTION 4. 149.143 (1) (am) 4. of the statutes is amended to read:

149.143 **(1)** (am) 4. Fourth, notwithstanding par. (bm), by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subds. 1. to 3. are insufficient to pay 60% of plan costs.

SECTION 5. 149.143 (1) (bm) 2. of the statutes is amended to read:

149.143 **(1)** (bm) 2. Fifty percent from adjustments to provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144.

SECTION 6. 149.143 (2) (a) 4. of the statutes is amended to read:

149.143 **(2)** (a) 4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year~~, subject to s. 149.142 (1) (b),~~ by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) 2. and as provided in s. 149.145.

SECTION 7. 149.143 (3) (a) of the statutes is amended to read:

149.143 **(3)** (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. ~~and s. 149.142 (1) (b).~~

SECTION 8. 149.143 (3) (b) of the statutes is amended to read:

149.143 **(3)** (b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (bm) ~~but subject to s. 149.142 (1) (b)~~.

SECTION 9. 149.143 (5) (a) of the statutes is amended to read:

149.143 **(5)** (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates~~, subject~~

~~to s. 149.142 (1) (b),~~ for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

SECTION 10. 149.143 (5) (b) of the statutes is amended to read:

149.143 **(5)** (b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually~~, subject to s. 149.142 (1) (b)~~. The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate~~, subject to s. 149.142 (1) (b)~~.

SECTION 11. 149.144 of the statutes is amended to read:

149.144 Adjustments to insurer assessments and provider payment rates for premium, deductible, and prescription drug copayment reductions. The department shall, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ~~ss. 149.142 (1) (b) and~~ s. 149.143 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165, deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

SECTION 12. 149.145 of the statutes is amended to read:

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143,

149.144, and 149.146 for determining premium rates, insurer assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) ~~and subject to s. 149.142 (1) (b)~~, from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.

SECTION 13. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. ~~Subject to s. 149.14 (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under this section over which the plan will pay ~~100%~~ 100 percent of covered costs for prescription drugs. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board~~ under this section is $400. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. Subject to s. 149.14 (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments ~~and~~ any ~~coinsurance~~ paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

SECTION 9321. Initial applicability; health and family services.

(1) HEALTH INSURANCE RISK–SHARING PLAN PRESCRIPTION DRUG COPAYS AND OUT–OF–POCKET LIMITS. The treatment of sections 149.14 (5) (e), 149.142 (1) (b) and

(2), 149.143 (1) (am) 4. and (bm) 2., (2) (a) 4., (3) (a) and (b), and (5) (a) and (b), 149.144, 149.145, and 149.146 (2) (am) 5. of the statutes first applies to prescription drug coverage in the first plan year beginning after the effective date of this subsection, on July 1, 2006

(END)

SECTION 9421. Effective Date; Health and Family Services.

(#) HEALTH INSURANCE RISK-SHARING PLAN PAYMENT RATE FOR PRESCRIPTION DRUGS. The treatment of sections 149.142 (1) (b) and (2), 149.143 (1) (am) 4. and (bm) 2., (2) (a) 4., (3) (a) and (b), and (5) (a) and (b), 149.144, and 149.145 of the statutes takes effect on October 1, 2005.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0578/P2dn
CMH&PJK:jld:rs

Sue:

On the basis of Shelley Malofsky's comments in the email sent by Curtis Cunningham, we removed the reference to "coinsurance" in the last sentence of ss. 149.14 (5) (e) and 149.146 (2) (am) 5. In the previous version, we had added the word "any" before "coinsurance" to give DHFS flexibility.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0578/P2dn
PJK:jld:rs

January 18, 2005

Sue:

On the basis of Shelley Malofsky's comments in the email sent by Curtis Cunningham, we removed the reference to "coinsurance" in the last sentences of ss. 149.14 (5) (e) and 149.146 (2) (am) 5. In the previous version, we had added the word "any" before "coinsurance" to give DHFS flexibility.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.state.wi.us

Hanaman, Cathlene

From: Kahler, Pam
Sent: Monday, January 24, 2005 9:31 AM
To: Hanaman, Cathlene
Subject: FW: LRB Draft: 05-0578/P1 HIRSP pharmacy reform

Importance: High

Cathlene:

Sue J. left me a message about making these changes permissive. She wants a call back on whether this can be done. Thanks.

Pam

-----Original Message-----
From: Jablonsky, Sue
Sent: Monday, January 24, 2005 9:00 AM
To: Kahler, Pam
Subject: FW: LRB Draft: 05-0578/P1 HIRSP pharmacy reform
Importance: High

-----Original Message-----
From: Cunningham, Curtis
Sent: Monday, January 24, 2005 8:47 AM
To: Jablonsky, Sue
Cc: Boroniec, Priscilla; Dombrowicki, Angela; Kristan, Margaret; Moody, Mark; Bove, Fredi-Ellen; Megna, Richard
Subject: Fwd: LRB Draft: 05-0578/P1 HIRSP pharmacy reform
Importance: High

Sue,
Please see the attached e-mail. HCF would like this proposal to be permissive not mandatory. Can this be done or is it to late?

Thanks

-----Original Message-----
Date: 01/21/2005 11:09 am -0600 (Friday)
From: Margaret Kristan
To: Cunningham, Curtis
CC: Boroniec, Priscilla; Bove, Fredi-Ellen; Dombrowicki, Angela; Moody, Mark
Subject: LRB Draft: 05-0578/P1 HIRSP pharmacy reform

Curtis,
Angie has talked with Mark Moody and Pris about the "mandatory" nature of the HIRSP pharmacy reform bill. Mark and Pris feel strongly that the proposal should be permissive in nature, i.e., allow the Department and the Board to implement the provisions and give the Department and Board some flexibility with regard to specifics of the design.

Margaret

State of Wisconsin
2005 – 2006 LEGISLATURE

LRB–0578/P2 P3
CMH&PJK:jld:rs
rmr

TODAY

DOA:.....Jablonsky, BB0041 – HIRSP pharmacy reform

FOR 2005–07 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The Health Insurance Risk–Sharing Plan (HIRSP) under current law provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. DHFS and a board of governors (board) administer HIRSP.

Under current law, HIRSP payment rates for prescription drugs are the same as payment rates under the Medical Assistance (MA) program. This bill allows DHFS, with the approval of the board, to set HIRSP prescription drug payment rates.

Under current law, DHFS is allowed by rule to establish for prescription drug coverage copayment amounts, coinsurance rates, and copayment and coinsurance out–of–pocket limits over which HIRSP will pay 100 percent of the covered costs incurred by the covered person during the remainder of the calendar year. This bill ~~requires~~ allows DHFS to establish a three–tiered copayment structure for prescription drug

benefits, with covered persons paying $5, $15, and $35 for most generic and brand name prescription drugs. This bill establishes the out–of–pocket limit for prescription drug coverage at $300 for persons who are also covered under Medicare and at $300 or $400 for other covered persons, depending on coverage selected. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limits; the $35 copayment amount does not count toward the out–of–pocket limits. This bill also allows DHFS to change the copayment and out–of–pocket limits by administrative rule.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 149.14 (5) (e) of the statutes is amended to read:

149.14 **(5)** (e) ~~Subject to sub. (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under sub. (3) (d) copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under sub. (3) (d) over which the plan will pay 100% of covered costs under sub. (3) (d) is $300. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. The department may provide subsidies for prescription drug copayment amounts paid by eligible persons under s. 149.165 (2) (a) 1. to 5. ~~Any copayment amount, coinsurance rate, or out–of–pocket limit established under this paragraph is subject to the approval of the board~~ Subject to sub. (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments ~~and coinsurance~~ paid by an eligible person under this paragraph are separate from and do not count toward the deductible and covered costs not paid by the plan under pars. (a) to (c).

SECTION 2. 149.142 (1) (b) of the statutes is amended to read:

149.142 **(1)** (b) The payment rate for a prescription drug shall be ~~the allowable charge paid under s. 49.46 (2) (b) 6. h. for the prescription drug. Notwithstanding s. 149.17 (4), the department may not reduce the payment rate for prescription drugs below the rate specified in this paragraph, and the rate may not be adjusted under s. 149.143 or 149.144~~ set by the department, subject to the approval of the board.

SECTION 3. 149.142 (2) of the statutes is amended to read:

149.142 **(2)** ~~Except as provided in sub. (1) (b), the~~ The rates established under this section are subject to adjustment under ss. 149.143 and 149.144.

SECTION 4. 149.143 (1) (am) 4. of the statutes is amended to read:

149.143 **(1)** (am) 4. Fourth, notwithstanding par. (bm), by increasing insurer assessments, excluding assessments under s. 149.144, and adjusting provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144, in equal proportions and to the extent that the amounts under subds. 1. to 3. are insufficient to pay 60% of plan costs.

SECTION 5. 149.143 (1) (bm) 2. of the statutes is amended to read:

149.143 **(1)** (bm) 2. Fifty percent from adjustments to provider payment rates, ~~subject to s. 149.142 (1) (b) and~~ excluding adjustments to those rates under s. 149.144.

SECTION 6. 149.143 (2) (a) 4. of the statutes is amended to read:

149.143 **(2)** (a) 4. By the same rule as under subd. 3. adjust the provider payment rate for the new plan year~~, subject to s. 149.142 (1) (b),~~ by estimating and setting the rate at the level necessary to equal the amounts specified in sub. (1) (am) 4. and (bm) 2. and as provided in s. 149.145.

SECTION 7. 149.143 (3) (a) of the statutes is amended to read:

149.143 **(3)** (a) If, during a plan year, the department determines that the amounts estimated to be received as a result of the rates and amount set under sub. (2) (a) 2. to 4. and any adjustments in insurer assessments and the provider payment rate under s. 149.144 will not be sufficient to cover plan costs, the department may by rule increase the premium rates set under sub. (2) (a) 2. for the remainder of the plan year, subject to s. 149.146 (2) (b) and the maximum specified in sub. (2) (a) 2., by rule increase the assessments set under sub. (2) (a) 3. for the remainder of the plan year, subject to sub. (1) (bm) 1., and by the same rule under which assessments are increased adjust the provider payment rate set under sub. (2) (a) 4. for the remainder of the plan year, subject to sub. (1) (bm) 2. ~~and s. 149.142 (1) (b).~~

SECTION 8. 149.143 (3) (b) of the statutes is amended to read:

149.143 **(3)** (b) If the department increases premium rates and insurer assessments and adjusts the provider payment rate under par. (a) and determines that there will still be a deficit and that premium rates have been increased to the maximum extent allowable under par. (a), the department may further adjust, in equal proportions, assessments set under sub. (2) (a) 3. and the provider payment rate set under sub. (2) (a) 4., without regard to sub. (1) (bm) ~~but subject to s. 149.142 (1) (b)~~.

SECTION 9. 149.143 (5) (a) of the statutes is amended to read:

149.143 **(5)** (a) Annually, no later than April 30, the department shall perform a reconciliation with respect to plan costs, premiums, insurer assessments, and provider payment rate adjustments based on data from the previous calendar year. On the basis of the reconciliation, the department shall make any necessary adjustments in premiums, insurer assessments, or provider payment rates~~, subject~~

~~to s. 149.142 (1) (b),~~ for the fiscal year beginning on the first July 1 after the reconciliation, as provided in sub. (2) (b).

SECTION 10. 149.143 (5) (b) of the statutes is amended to read:

149.143 **(5)** (b) Except as provided in sub. (3) and s. 149.144, the department shall adjust the provider payment rates to meet the providers' specified portion of the plan costs no more than once annually~~, subject to s. 149.142 (1) (b)~~. The department may not determine the adjustment on an individual provider basis or on the basis of provider type, but shall determine the adjustment for all providers in the aggregate~~, subject to s. 149.142 (1) (b)~~.

SECTION 11. 149.144 of the statutes is amended to read:

149.144 Adjustments to insurer assessments and provider payment rates for premium, deductible, and prescription drug copayment reductions. The department shall, by rule, adjust in equal proportions the amount of the assessment set under s. 149.143 (2) (a) 3. and the provider payment rate set under s. 149.143 (2) (a) 4., subject to ~~ss. 149.142 (1) (b) and~~ s. 149.143 (1) (am), sufficient to reimburse the plan for premium reductions under s. 149.165, deductible reductions under s. 149.14 (5) (a), and any prescription drug copayment reductions under s. 149.14 (5) (e). The department shall notify the commissioner so that the commissioner may levy any increase in insurer assessments.

SECTION 12. 149.145 of the statutes is amended to read:

149.145 Program budget. The department, in consultation with the board, shall establish a program budget for each plan year. The program budget shall be based on the provider payment rates specified in s. 149.142 and in the most recent provider contracts that are in effect and on the funding sources specified in ss. 149.143 (1) and 149.144, including the methodologies specified in ss. 149.143,

149.144, and 149.146 for determining premium rates, insurer assessments, and provider payment rates. Except as otherwise provided in s. 149.143 (3) (a) and (b) ~~and subject to s. 149.142 (1) (b)~~, from the program budget the department shall derive the actual provider payment rate for a plan year that reflects the providers' proportional share of the plan costs, consistent with ss. 149.143 and 149.144. The department may not implement a program budget established under this section unless it is approved by the board.

SECTION 13. 149.146 (2) (am) 5. of the statutes is amended to read:

149.146 **(2)** (am) 5. ~~Subject to s. 149.14 (8) (b), the department may, by rule under s. 149.17 (4), establish for prescription drug coverage under this section copayment amounts, coinsurance rates, and~~ The department shall establish a 3–tiered copayment structure for prescription drugs with copayments of $5, $15, and $35. The copayment ~~and coinsurance~~ out–of–pocket ~~limits~~ limit for prescription drug coverage under this section over which the plan will pay 100% of covered costs for prescription drugs~~. Any copayment amount, coinsurance rate, or out–of–pocket limit established under this subdivision is subject to the approval of the board~~ under this section is $400. Only the copayment amounts of $5 and $15 count toward the out–of–pocket limit. Subject to s. 149.14 (8) (b), the department may change, by rule under s. 149.17 (4), the copayment amount and out–of–pocket limit. Copayments ~~and coinsurance~~ paid by an eligible person under this subdivision are separate from and do not count toward the deductible and covered costs not paid by the plan under subds. 1. to 3.

SECTION 9321. Initial applicability; health and family services.

(1) HEALTH INSURANCE RISK–SHARING PLAN PRESCRIPTION DRUG COPAYS AND OUT–OF–POCKET LIMITS. The treatment of sections 149.14 (5) (e) and 149.146 (2) (am) 5. of the statutes first applies to prescription drug coverage on July 1, 2006.

SECTION 9421. Effective dates; health and family services.

(1) HEALTH INSURANCE RISK–SHARING PLAN PAYMENT RATE FOR PRESCRIPTION DRUGS. The treatment of sections 149.142 (1) (b) and (2), 149.143 (1) (am) 4. and (bm) 2., (2) (a) 4., (3) (a) and (b), and (5) (a) and (b), 149.144, and 149.145 of the statutes takes effect on October 1, 2005.

(END)

Hanaman, Cathlene

From: Jablonsky, Sue
Sent: Monday, January 24, 2005 2:37 PM
To: Hanaman, Cathlene
Subject: FW: Fwd: FW: LRB Draft: 05-0578/P3 HIRSP pharmacy reform

Sorry...

-----Original Message-----
From: Cunningham, Curtis
Sent: Monday, January 24, 2005 2:02 PM
To: Jablonsky, Sue
Cc: Kristan, Margaret
Subject: Re: Fwd: FW: LRB Draft: 05-0578/P3 HIRSP pharmacy reform

Sue here are Margaret's comments. She does have some changes.

-----Original Message-----
Date: 01/24/2005 01:18 pm -0600 (Monday)
From: Margaret Kristan
To: Cunningham, Curtis
CC: Dombrowicki, Angela; Malofsky, Shelley
Subject: Re: Fwd: FW: LRB Draft: 05-0578/P3 HIRSP pharmacy reform

Hi, Curtis-
Thank you and thank Sue for the quick turnaround. I talked with Shelley and she commented that the bill still provides no flexibility regarding which copayment amounts apply to the annual max out of pocket limits. It was my understanding that Mark was looking for flexiblity on the specifics of how HIRSP would implement a 3-tiered drug copayment system, so I think that still needs to be changed. Line 12 on 2nd page and line 18 on page 6 are line references at which the language could be changed to give the Department and Board authority to determine which copayment apply to out of pocket max (in addition to copayment amounts and out of pocket limits).

Also, we'd like to promulgate these rules under the emergency rule procedures without being required to make a finding of emergency.

Angie--if we've missed anything, please let me know.

Margaret

>>> Curtis Cunningham 01/24/05 12:03PM >>>
This draft makes the proposal permissive. Let me know if you have any comments as quickly as possible.